Kentucky Medicaid Program
Request to replace Social Security Number with
FEIN to an Individual provider's file

Please add FEIN number _____ to my individual Kentucky Medicaid provider number of _____.I hereby declare that I am the sole owner of this FEIN.

Provider Tax Structure**: Please check only one (1).**

☐ (A) Individual
☐ (B) Sole Proprietor
☐ (C) Partnership
☐ (D) Estate/Trust
☐ (E) Corporation (**please attach a list of Officers' and Board Members' names or list below**).
☐ (F) Public Service Corporation (**please attach a list of Officers' and Board Members' names or list below**).
☐ (G) Government/Non-Profit (**please attach a list of Officers' and Board Members' names or list below**).
☐ (H) Limited Liability Company (**please attach a list of Officers' and Board Members' names or list below**).

Officers' and Board Members' Names:

I certify that I own the above referenced FEIN 100% and I am the sole owner of the FEIN.

_____
(Individual Provider printed name)

_____ _____
Individual Provider Signature Date signed

(IRS letter of verification of FEIN or Official IRS documentation stating FEIN. FEIN must be pre-printed by IRS on documentation. W-9 forms will <u>not</u> be accepted.)

***Please Note*: The individual provider must be the sole owner of the FEIN and own the FEIN 100%.**

If your physical, pay-to, mailing, or 1099 address has changed, please complete a Map-529 form located at http://www.chfs.ky.gov/dms/provEnr/Forms.htm.

Please return form to the following address: KY Medicaid, P.O. Box 2110 Frankfort, KY 40602

CLEAR FORM